CalPERS Benefit Services Division, P.O. Box 2796, Sacramento, CA 95812-2796
Telecommunications Device for the Deaf - (916) 326-3240 • FAX (916) 326-3934 • (800) 352-2238

# Medical Report

Applicant's Social Security Number

## Notice To Physician

The following information is needed for use in connection with the patient's application for disability retirement allowance under the California Public Employees' Retirement Law. Please provide your full reply, in order to completely describe the nature and severity of impairment.

Applicant's Name | Date of Birth | Occupation

**For Kaiser Patients, Medical Record Number:** _____

## Part 1 Physical Measurement

Height: _____ Weight : _____

## Part 2 History

Date of First Visit: ____/____/____ Date of Last Visit: ____/____/____
Date Present Illness or Injury Occurred: ____/____/____ Date Applicant Unable To Work: ____/____/____
Applicant Injured on Job? ❑ Yes ❑ No If Yes, How Did Injury Occur? _____
Applicant Injured Other Than on Job? ❑ Yes ❑ No If Yes, How Did Injury Occur? _____
Remarks:

## Part 3 Present Condition

Subjective Symptoms: _____
Objective Findings:

Report X-rays, EKGs, laboratory or diagnostic test, with dates. Use additional sheets if necessary.

## Part 4 Diagnosis

## Part 5 Incapacity

List Specific Activity Restrictions (if any):_____

Presently Incapacitated from Performance of Usual Duties? ❑Yes ❑No If Yes, Describe.

_____

Will Incapacity Be Permanent? ❑Yes ❑No If Not, Probable Duration: ❑ 3 mos. ❑ 6 mos. ❑ 1 yr. ❑ 2 yrs.

Applicant Mentally Able to Handle Financial Affairs & Enter Into Legally Binding Contracts? ❑ Yes ❑ No

Applicant Competent to Endorse Checks with the Realization of Nature & Consequence of the Act? ❑ Yes ❑ No

**If disability is due to the following conditions, describe latest finding and dates.**

**Cardiac**

Precise Diagnosis Including Functional and Therapeutic Classification, American Heart Association:

_____ _____

Blood Pressure

**Pulmonary**

Acute Attacks: _____

Frequency/Duration/Severity

Emphysema: _____

**Orthopedic**

Physical Findings: (For all joints involved – deformities, tissue & bone destruction, range of motion.)

_____

X-ray Report: _____

**Neurological (Add separate narrative if necessary.)**

Describe any of the following conditions: (Indicate severity, distributions, & residual function.)

❑ Atrophy ❑ Hemiplegia ❑ Tremors ❑ Paralysis ❑ Mental Disturbances ❑ Impaired Speech ❑ Gait

_____

**Visual**

Visual Acuity After Best Correction Right: _____ Left: _____

Visual Fields (attach chart if available) Right: _____ Left: _____

## Part 6 Signature

Mail completed report directly to the CalPERS. **Do not give to applicant**.

CalPERS has my permission to release a photocopy of report to applicant, upon written request. ❑ Yes ❑ No

_____

Printed Name of Physician or Organization

_____

Signature Title

_____

Address City State ZIP

_____

Telephone Number Date